Public Health England

# Commissioning treatment for dependence on prescription and over-the-counter medicines: a guide for NHS and local authority commissioners

## What is the issue?

The 2010 Drug Strategy covers "dependence on all drugs, including prescription and over-the-counter medicines," and local responses to drug misuse and dependence are also expected to cover dependence and other problems with medicines (sometimes called addiction to medicines (ATM)).

The 2013 JSNA support pack for commissioners (NTA, 2012) suggested that commissioners ask:

- "Are innovative responses in place or being developed to prevent, identify and treat evidenced and emerging need in relation to addiction to prescribed and over-the-counter medicines?"

And that prescription and over-the-counter (OTC) medicines are included in wider considerations of:

- Waiting times for community-based interventions that provide access within three weeks of referral
- The treatment system's ability to respond rapidly and effectively to changing patterns of substance misuse.

## What medicines and who is using them?

Although dependence on prescribed benzodiazepines in the community receives most media attention, health and public health commissioners will want to ensure that locally appropriate responses are available for problems with a full range of prescription and OTC medicines, including, but not limited to:

- Benzodiazepines and z-drugs, prescribed mainly for anxiety (benzodiazepines only) and insomnia
- Opioid and some other pain medicines, both prescribed and bought over-the-counter
- Stimulants, prescribed for ADHD or slimming
- Some OTC cough and cold medicines, and anti-histamines and stimulants.

There is a fuller list at appendix A.

There are distinct but overlapping populations using these medicines and they may need different approaches:

- Those who use prescription and OTC medicines as a supplement or alternative to illicit drugs, or as a commodity to sell
- Those who overuse prescription or OTC medicines to cope with genuine or perceived physical or psychological symptoms
- Those for whom the prescribed use of a medicine inadvertently led to dependence, sometimes called involuntary or iatrogenic addiction.

Problems with prescription medicines occur in the community and in secure environments but the medicines used, populations using them and reasons for misuse or dependence may differ.

Health and wellbeing boards, through their joint strategic needs assessment (JSNA) and joint health and wellbeing strategy, will want to support health and public health commissioners to understand local need in relation to addiction to medicines, so that together they can commission appropriate responses. Health commissioners will likely include both NHS England local teams and clinical commissioning groups.

## Understanding local need

Commissioners will want a full picture of who is misusing or dependent on what medicines from which sources in order to commission appropriate local responses.

### Sources of data

Date on prescriptions dispensed in the community is made available to local partnerships via the prescribing toolkit provided by NHS Prescription Services. There is more information in the NTA's Addiction to medicine report (NTA, 2011) and from the NHS Business Services Authority.

Public health commissioners can ask clinical commissioning groups (CCGs) for information on the prescribing patterns of GPs.

The NTA's JSNA support pack for strategic partners – sent to every partnership – includes local NDTMS data on people in treatment for prescription and OTC medicines, and drug users who have a problem with these as well as illicit drugs (see below).

National Drug Treatment Monitoring System (NDTMS) quarterly (or Green) reports include data on presenting substance that can be used to track changes in the profile of medicines causing problems.

However, NDTMS data only covers those seeking specialist treatment so may not be most useful for gaining an understanding of people who do not approach treatment services or as a source of early intelligence on developing problems with medicines.

Other useful local data sources may include any local ATM and primary-care services that do not report to NDTMS.

### Other ways of finding out

Controlled drugs accountable officers (CDAOs) monitor, audit and ensure the safe management and use of drugs controlled under the Misuse of Drugs Act. CDAOs in NHS England local area teams are the accountable officers for their CD local intelligence networks and they have a surveillance role over community prescribing and pharmacies. NHS trusts and independent hospitals are also required to appoint CDAOs. Many of the medicines listed in appendix A are controlled drugs so will be considered by accountable officers in their work.

Commissioners might also request practice or service-based audits of case notes to inform future commissioning.

Consultation with those affected by addiction to medicines or likely to encounter it in their work is an invaluable source of additional information. Appropriate local consultees might include service users (drug & alcohol treatment, mental health), treatment and other service providers, peer mentors and volunteers, pharmacy groups, police, probation, primary and social care staff, tenancy and housing support services, etc.

It has been agreed nationally that the New Medicine Service (NMS) and Medicines Use Reviews (MUR) are not suited to improving benzodiazepine prescribing.

## What's different about prisons and other secure environments?

The medicines used, and reasons for their use, in secure environments generally mirror those in the general population although the scale and nature may differ. Prisoners may be more likely than the general population to suffer from conditions such as insomnia, anxiety and pain that lead them to seek medicines liable to dependence. They may also be more likely to claim these conditions as a way of obtaining medicines for personal misuse or as currency. They will also have less access to OTC medicines.

PHE will publish a guide on managing persistent pain in secure environments, in June 2013. This will complement Safer Prescribing in Prisons (RCGP, 2011).

Figure 1: Example of JSNA data

**PRESCRIPTION ONLY MEDICINE/OVER THE COUNTER MEDICINE (POM/OTC)**

Local ● National ●

People in treatment for prescription-only medicines (POM) or over the counter medicines (OTC), and drug users who have a problem with these as well as illicit drugs are presented below. The drug strategy encourages local areas to ensure their services have the capacity to help people get the support that they need for POM and OTC dependence.

| | | Local | Proportion of treatment population | National | Proportion of treatment population |
|---|---|---|---|---|---|
| **Number of adults citing POM/OTC use** | Illicit use | 378 | 18% | 28,842 | 14% |
| | No illicit use | 106 | 5% | 3,906 | 2% |
| | Total | 484 | 23% | 32,748 | 16% |

**Proportion of treatment population citing POM/OTC use**

## Responding to local need

### Prevention

This guide is concerned with the treatment of problems of dependence that have arisen in people prescribed certain medicines or buying them. However, commissioners will also want to consider how problems can be prevented. Primary and secondary healthcare, public health and social care can together contribute to:

- Ensuring that psychological and other treatments are available as alternatives to prescribing medicines, including through the Increasing Access to Psychological Therapies (IAPT) programme
- Ensuring that the public and patients are aware of the problems that can arise with these medicines, and understand why their availability may be limited in duration or quantity
- Ensuring that doctors, pharmacists, social care staff and others are aware of current guidance on these medicines and are alert to any developing problems in patients
- Monitoring and responding to prescribing and purchasing patterns.

### Who and where?

Primary care will be the first port of call for most patients dependent on prescription or OTC medicines.

If patients are not comfortable returning to the GP who prescribed the medicine on which they have become dependent, they have the right to see another GP or register with another practice.

Patients, and sometimes their GPs, may be unaware that there is a problem with a prescription or OTC medicine. ATM outreach services in primary care practices can help to identify problems and link patients to appropriate treatment.

Specialist responses can support and advise GPs to provide treatment and to recognise when a patient needs more specialist care, and can treat patients who cannot be treated in standard primary care. Commissioners will need to ensure that those providing specialist responses consider:

- The knowledge and expertise needed to treat patients, some of whom may have been using medicines for many years and may need long-term withdrawal and extensive support, including for co-occurring and emerging mental and physical health problems
- Where and when interventions should be provided. Patients may be uncomfortable sharing space with those using illicit drugs and – whether ultimately this should be accepted or challenged – responses need to focus on engaging and retaining people, which may mean them providing (and commissioners funding) separate ATM sessions, premises or services.

These specialist responses may be in existing or newly-commissioned services that deal with a range of drug and alcohol issues or they may be complemented or better provided by separate, dedicated, ATM services and support groups. This is necessarily a local decision in response to local need, history and context.

This guide is not intended to provide clinical advice on withdrawal from long-term benzodiazepine dependence. However, commissioned treatment will be based on clinical advice, which you can read more about in the publications listed in ‘further reading’ below.

Commissioners will want to ensure that commissioned services include appropriate clinical governance mechanisms to ensure safe and effective prescribing of medicines liable to dependence and for the treatment of dependence, and to prevent and detect diversion of prescription medicines by patients.

### How?

Primary care practices can be expected to respond to ATM problems as part of their regular patient care, within the terms of the General Medical Services (GMS) contract.

Specialist responses will usually be commissioned as part of the drug and alcohol misuse treatment system, from one or more of the following, as locally appropriate:

- Primary care (providing an enhanced service)
- A provider of integrated drug and alcohol treatment services
- A dedicated (often voluntary sector) ATM provider.

It will also be important to ensure that pain management, mental health, and drug and alcohol treatment services work together and provide coordinated and integrated responses to patients.

Voluntary sector responses – which can range from informal support groups to fully-fledged service provider organisations – may have arisen and been supported in a number of ways, including:

- From member support and donations
- Fundraising and charitable trust funding
- Directly commissioned locally:

  As part of drug treatment by the NHS or local authority

  As part of mental health treatment by the NHS or local authority
- Funded as part of local authority support for the voluntary and community sector.

Commissioners contracting with voluntary sector providers will want to consider and honour The Compact between government and the voluntary and community sector so that, for instance, services are given multi-year funding where possible.

A checklist for consideration of addiction to medicines in needs assessment is included as Appendix B.

## References and further reading

### References

Home Office (2010) Drug Strategy 2010 – Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Free Life. London: Home Office.

NTA (2011) Addiction to medicine: an investigation into the configuration and commissioning of treatment services to support those who develop problems with prescription-only or over-the-counter medicine. London: National Treatment Agency for Substance Misuse.

NTA (2012) JSNA support pack for commissioners of recovery in communities 2013. London: National Treatment Agency for Substance Misuse.

RCGP (2011) Safer Prescribing in Prisons: guidance for clinicians. London: Royal College of General Practitioners.

Reed K, Bond A, Witton J, Cornish R, Hickman M & Strang J (2011) The changing use of prescribed benzodiazepines and z-drugs and of over-the-counter codeine-containing products in England: a structured review of published English and international evidence and available data to inform consideration of the extent of dependence and harm. London: National Addiction Centre.

### Further reading

The Faculty of Pain Medicine has published guidance on the commissioning of local pain services.

Commissioners wanting to better understand the clinical issues involved in treating addiction to medicines can refer to the following:

- The British National Formulary contains current advice on appropriate prescribing and on withdrawal
- The NICE Clinical Knowledge Summary on benzodiazepine and z-drug withdrawal provides an accessible summary of the evidence base and guidance on best practice for primary care practitioners
- Drug Misuse and Dependence: UK Guidelines on Clinical Management is principally concerned with the treatment of those dependent on illicit drugs but also covers benzodiazepine misuse and dependence
- The Ashton manual describes a widely-supported protocol for withdrawal from long-term benzodiazepine dependence
- The British Pain Society publishes a range of professional guidance on clinical and other pain matters

A range of NICE guidance covers the use of medicines for insomnia, anxiety, pain, etc that are liable to misuse and dependence.

# Appendix A. Some medicines liable to misuse or dependence

## Notes:

- The proper or generic medicine name is followed by:

  notes or other names, including those used in medicine combinations, in brackets ()

  example brand names, some no longer available in UK, in square brackets []

- The list does not distinguish between medicines that are prescription-only or available over-the-counter without a prescription (either from pharmacies only or from any shop, often only in limited quantities). For more information, see the British National Formulary
- The remit of this guide is restricted to medicines with psychoactive properties, as is this list. Other medicines, such as, for example, laxatives and anabolic steroids, may also be liable to misuse but are not included here.
- A comprehensive list of medicines recorded in the National Drug Treatment Monitoring System is contained in annex 1 of the NTA's 2011 Addiction to medicine report.

## Benzodiazepines and z-drugs

- Benzodiazepines

  Chlordiazepoxide [Librium]

  Diazepam [Valium]

  Loprazolam

  Lorazepam [Ativan]

  Nitrazepam [Mogadon]

  Oxazepam

  Temazepam

  Clonazepam

- Z-drugs (although z-drugs differ chemically from the benzodiazepines, they have the same pharmacological properties)

  Zaleplon [Sonata]

  Zolpidem [Stilnoct]

  Zopiclone [Zimovane]

## Opioid pain medicines

- Pethidine
- Methadone [Physeptone]
- Oxycodone [OxyNorm]
- Tramadol [Zydol]
- Codeine (with paracetamol = co-codamol) [Nurofen Plus]
- Dihydrocodeine (with paracetamol = co-dydramol) [Paramol]

## Epilepsy and pain medicines

- Pregabalin (also licensed for anxiety) [Lyrica]
- Gabapentin

## Stimulants

- Methylphenidate [Ritalin]
- Dexamfetamine
- Modafinil
- Caffeine [Pro-plus]

## Some cough and cold, anti-diarrhoea, and anti-allergy medicines

- Opium tincture [Gee's linctus]
- Codeine linctus
- Anhydrous morphine [J.Collis Browne's Mixture]
- Kaolin and morphine
- Sedative antihistamines such as promethazine [Phenergan] and diphenhydramine [Benadryl, Nytol]

Some people also report problems withdrawing from antidepressants (e.g. amitriptyline, fluoxetine [Prozac], paroxetine [Seroxat], venlafaxine [Efexor]), and it is generally best to taper off the dose of an antidepressant rather than stop it suddenly. However, there is no clear evidence that these medicines can produce dependence according to internationally accepted criteria.

# Appendix B. Commissioning for addiction to medicines: needs assessment checklist

## Range of medicines:

- Benzodiazepines and z-drugs – prescribed and illicitly obtained
- Opioid and some other pain medicines – prescription, OTC and illicitly obtained
- Stimulants, prescribed for ADHD or slimming
- Other OTC medicines

## Range of users:

- Prescription and OTC medicines as a supplement or alternative to illicit drugs, or as a commodity to sell
- Overuse of prescription or OTC medicines to cope with genuine or perceived physical or psychological symptoms
- Inadvertently dependent following prescribed use of a medicine

## Range of environments:

- Community
- Hospitals
- Secure environments

## Existing services/responses:

- Primary care
- Specialist treatment
- Voluntary sector support groups and services

## Data sources:

- NHS Prescription Services
- JSNA support data from NDTMS
- Quarterly (Green) NDTMS reports
- Local ATM and primary care services

## Consult:

- Clinicians (doctors, pharmacists, nurses, etc and their local groups)
- Current, potential and past service users
- Controlled drugs accountable officers

## Joint work between HWBs and local and national commissioners, specifying their current and desired provision, etc.